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ORIGINAL ARTICLE

''Risky Business'': a critical analysis of the role of crisis resolution and home treatment teams

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Abstract

Background: In 2000, the Department of Health for England recommended the creation of crisis resolution and home treatment teams (CRHTs) in order to reduce the number and length of psychiatric hospital admissions. Central to this was the role of gate-keeping all potential admissions.
Aim: To examine the interface between crisis resolution and home treatment and other mental health services.
Methods: Semi-structured interviews with mental health professionals ($n = 25$) at eight sites within one Strategic Health Authority region.
Results: Despite wide variation in approach and provision, all teams were confronting common issues related to tensions at both ends of the service user trajectory – on initial assessment and on discharge.
Conclusion: The CRHT model is likely to be most effective when there is low staff turnover, flexibility in inter-team working arrangements and senior practitioners have both acute and community experience. Rather than being seen primarily as gatekeeper to the acute service, it would be better to take a system approach and view the CRHT as a resource for clients awaiting discharge or seeking to avoid hospital admission that is equally available to both acute and community services.

Keywords

Community mental health, Crisis resolution, home treatment, mental illness, psychiatric services

History

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Introduction

In 2000, the Department of Health for England recommended the creation of crisis resolution and home treatment teams (CRHTs). The aim was to reduce the number and length of hospital admissions through provision of intensive home support for people experiencing acute mental health crises who would otherwise be admitted to hospital (Department of Health, 2000). CRHTs were given the task of assessing all potential hospital admissions and deciding whether or not admission is required. Gate-keeping was seen as pivotal to their success (National Audit Office, 2007), in the belief that, without it, other professionals would continue to admit people to hospital as before (McGlynn, 2006). From the start, relationships with other parts of the service were likely to be confrontational and, according to McGlynn (2006), ''this issue has probably resulted in more friction than anything else between teams and between professional groups'' (McGlynn, 2006, p. 15).

A report for the Audit Office (Morgan, 2006) found that CRHT presence during assessment was thought by both CRHT members and ward managers to increase the likelihood of home treatment (HT) being considered as an alternative to admission. However, CRHT involvement was considered unnecessary in ~30% of the assessments. A national survey (Onyett et al., 2008) found inconsistency in performance of the gate-keeping function, with 21% of teams gate-keeping 50% or fewer proposed admissions and inter-team difficulties the main obstacle to fidelity to the CRHT model (Middleton et al., 2008). Despite these shortcomings, CRHTs have been linked to reduced hospital admissions, service user satisfaction (e.g. Barker et al., 2011) and lower service costs (e.g. McCrone et al., 2009). However, the evidence is patchy, and other studies report increased compulsory admissions and little or no effect on bed usage (e.g. Tyrer et al., 2010). An analysis of national data found no significant differences in admissions between primary care trusts with and without CRHTs, prompting speculation that gate-keeping fidelity might explain the differences (Jacobs & Barrenho, 2011). A recent systematic review concluded that, given the weak evidence base, there was ''no compelling evidence'' of either CRHTs' effectiveness or the assumption that they are the best way of reducing admissions (Hubbeling & Bertram, 2012).

The new teams were largely funded through ward closures (Lodge, 2013), and decline in the number of NHS in-patient beds has continued (Buchanan, 2013) to the point that many now believe that the current focus on preventing hospital

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admissions is driven more by bed shortages than the needs of patients. The CRHT role and gate-keeping, in particular, remains controversial (Lodge, 2013). It is this role which we examine in more detail here, using material drawn from a broader, critical review of CRHT services in one Strategic Health Authority region (Rhodes & Giles, 2011).

Study objectives

(1) To provide an overview of services, policies and practices across the region.
(2) To identify the main differences between different providers/localities.

Methods

The study took place over 6 months in 2010 and involved: (i) a descriptive overview of CRHT services in the region, followed by (ii) more detailed analysis of three sites.

Phase one

Face-to-face interviews, using a semi-structured questionnaire, were conducted with a key informant (service manager/team leader) from each service provider at participants' place of work. Topics covered: the local configuration of services; policies and practices; team composition; services provided; clinical assessments; how caseloads, gate keeping and referral pathways were managed.

Phase two

Three sites exemplifying different approaches to provision were selected for detailed study: site 1 appeared to follow most closely Mental Health Policy Implementation Guidance (Department of Health, 2001); site 3 was the only service to include explicitly social distress in its criteria for client acceptance; site 5 had disbanded the CRHT and absorbed its functions into a newly configured acute mental health team. The team leader, a mental health nurse, approved mental health professional (AMHP) and psychiatrist were interviewed at each site. A member of a Community Mental Health Team (CMHT) was also interviewed. Interviews were conducted by one interviewer in phase one and three in phase two; all were involved in subsequent data analysis.

Interviews lasted 1–2 h, were audio-recorded (with participants' permission) and fully transcribed. Issues raised in Phase 1 were explored in greater depth. Topics included: identity and purpose, gate-keeping, early discharge, out-of-hours cover, referrals, role of psychiatrist, risk assessment and management, multidisciplinary working, relationships with other parts of the service, care plans and co-ordination, confidentiality, serious untoward incidents and safety issues.

Data analysis

Material from Phase 1 was used to produce descriptive summaries of service provision at each site. In Phase 2, data from each site were analyzed separately to produce a detailed description of services and their operation in each site. Data from all sites were then combined to investigate themes common across sites. Transcripts were coded by three researchers who met frequently to agree descriptive and later analytical themes. Descriptive themes remain ''close'' to the primary studies; analytical themes ''go beyond'' the primary studies and generate new interpretive constructs, explanations or hypotheses (Thomas & Harden, 2008). Discrepant information from different sources at the same site was checked with interviewees. Team leaders were sent a brief description of their service and asked to identify omissions or factual inaccuracies; they were also invited to comment on the final report. We received two responses relating to factual issues concerned with service configuration. The study has been reviewed by the regional mental health services forum.

Findings

About eight of the 11 services invited to take part accepted. Of the three that declined, one was undergoing re-organization, one was subject to external investigation, the third cited pressure of work.

Phase 1 revealed wide variation in approach and provision between sites and between teams in the same site, reflecting variation in historical development of services, geographical areas and populations served. Despite these differences, all teams were experiencing tensions within the role itself: internal tensions, in managing the distribution of resources between different functions, and external inter-professional and inter-team tensions at both ends of the client pathway – on admission, in respect of gate-keeping, and on discharge, as a result of delays in the discharge pathway.

Managing the distribution of resources

Teams reported tension between gate-keeping assessment and HT, with the former drawing resources away from the latter at times of high demand. Given their immediacy and urgency, gate-keeping assessment (what one person termed ''front end work'') tended to take precedence, with the result that resources for HT could become squeezed. This, in turn, could influence gate-keeping decisions, in that HT can only be offered if there are the resources to provide it. In the words of one person,

> If you get lots of referrals, then you're doing lots of front end stuff and it impacts on what you do further down the line. (AMHP, Site 11)

Gate-keeping

The gate-keeping role and disputes over assessments of service user risk (of harm to self and/or others) were an enduring source of inter-professional and inter-team tension. Relationships with other parts of the service, in particular CMHTs, were often reported to be strained.

Community practitioners questioned the legitimacy of CRHT expertise to conduct gate-keeping assessments, given their partial knowledge of clients and lack of a long term perspective, in particular knowledge of trigger factors and coping strategies that may have been disrupted in the period leading up to crisis. As one CMHT Leader (Site 5) explained:

> The last place we want our person to be is in hospital . . . So we do our best to not get them to that point. . . we put

> extra services in, we put extra visits in. We get to the point where there is no other option ... It's a frustrating thing being told ''No'' by somebody who has never even met the patient.

Where hospital admission was considered inevitable, gate-keeping was regarded as a bureaucratic impediment that unnecessarily prolonged the admission process for service users who were already highly distressed.

By contrast, CRHT workers complained that CMHT care coordinators had a lower toleration of risk.

> Our threshold for risk is much, much higher than other bits of the service and... they sometimes have a lot of trouble understanding and accepting why we haven't taken (a person) on. (Social Worker, Site 1)

Failure to gate-keep (i.e. to assess) all hospital admissions was often blamed, by CRHT workers, on attempts to by-pass the CRHT and have people admitted to hospital directly. However, they acknowledged that it was not possible for CRHT workers to attend all assessments, in particular Mental Health Act assessments for compulsory admission.

Gate-keeping assessment introduced an element of duplication, and service user feedback highlighted repeated assessment as a persistent complaint.

> The service user was being asked questions that the care coordinator could answer or was already documented elsewhere in their notes. (Team Leader, Site 8)

Delayed discharge

The short-term nature of CRHT intervention is dependent on rapid flow of clients through the service and transfer back or on to other services. All teams were experiencing delays in the discharge pathway to community care, and this was a source of inter-team tension and mutual recrimination.

> Sometimes we end up where the two the bits of the service are – I wouldn't say squabbling – but disagreeing as to whether it's appropriate for them (to take a person). (Psychiatrist, Site 1)

The CRHTs dealt with the backlog by reducing involvement to occasional telephone contact in order to release resources for new clients. Many teams reported large numbers of clients, for whom active intervention had ceased, who were simply awaiting discharge to community services – what many referred to as the ''green zone''[1]. In some areas, inpatients not needing intensive HT were discharged directly into the ''green zone'', bypassing the active case load altogether. Thus, two CRHTs found themselves acting as a buffer between acute and community services, absorbing excess work when neither service had capacity to accept new clients or take back old. Clients new to the service could sometimes wait weeks, even months, for the allocation of a CMHT care coordinator.

These problems can be traced, in part, to mutual lack of understanding of the different teams' working cultures.

> There is a basic difference in working practices, with CRHT specialising in chaotic and constantly changing situations requiring immediate and flexible action, whereas CMHTs have a diary-based schedule of regular pre-booked visits up to three weeks ahead. The consequence is great difficulty in arranging joint visits in general and joint discharge planning in particular, as this entails the CMHT worker re-juggling existing appointments. (Team Leader, Site 11)

Crisis resolution and home treatment teams perceived themselves to be (and operated as) an extension of the acute service, as reflected in professional backgrounds and experience of staff, working practices and culture. CRHTs were generally established at the same time as ward closures and ward staff had simply been transferred to the new teams. Familiarity with the culture and routines of the acute service facilitated relations with in-patient staff, but there was little shared experience and background with CMHT staff. Relationships with CMHTs were reported to work most effectively where senior practitioners had experience of working in both settings, had regular contact with CMHT leaders and/or routinely attended CMHT meetings. However, regular attendance was only reported at one site (11).

Managing risk

As with gate-keeping, the problem of delayed discharge revolved around disputes about risk. Interviewees observed that, with the creation of specialist CRHTs, community practitioners have had fewer opportunities to develop crisis management skills and, the less confident they are in dealing with crises, the more conservative they may become in their management of risk. This, in turn, fuelled disputes between specialist and non-specialist teams over client transfer from one to another. Support for this view was found in criticism of community service timidity and unwillingness to take on higher risk clients and CMHT complaints that they were asked to accept clients who were discharged too early.

Where referrers have learned to trust the judgments of gate-keepers, disputes about acceptable risk are likely to be fewer. Trust develops over time, and team stability on both sides of the interface was important; in one site (8), for example, the most stable CMHTs were reported to have developed more trusting relationship with the CRHT than those with higher staff turnover.

Experienced workers were reported to have the highest thresholds for risk and to be most likely to recommend HT as an alternative to admission. Despite the use of standard assessment tools, risk assessment was said to retain a strong element of personal judgment, and is therefore likely to be sensitive to changing service capacity to cope with demand.

[1]At least eight teams were using a traffic light system to classify clients in terms of priority of need for service input.

In some teams, there were complaints that the CRHT was being used inappropriately as an out-of-hours and weekend service for CMHTs.

> (T)here is a tendency... to see us as an out-of-hours extension of their service ... We get referrals purely because it's the weekend; we get referrals from care co-ordinators if they're going on a fortnight's holiday. (Site 1, Nurse)

Elsewhere, these situations were regarded as genuine gaps in service provision, with collaborative working extended to CMHT clients needing out-of-hours and week-end support. This was a ''grey area'' subject to local negotiation over appropriate roles, and where a degree of flexibility seemed desirable. Significantly, there was most flexibility where senior CRHT workers had personal experience of CMHT work.

Solutions

Some areas had attempted to redress the balance between gate-keeping, crisis resolution and HT by dropping ''crisis resolution'' from the team's name. At one site, for example, the CRHT had been re-launched as the Intensive Home Treatment Team to signal its renewed focus. Elsewhere, involvement in hospital discharge planning had been reduced to protect resources for HT. This had a knock-on effect for other services, notably the CMHT, which had to redeploy its own staff to provide extra support to patients on early discharge. Another strategy was to separate the gate-keeping role from the provision of HT. However, at the site (Site 5) where this had been introduced, HT workers were also required to work on inpatient wards, with the result that resources for HT were not protected.

Strategies to enforce the gate-keeping role included: a formal requirement of gate-keeping for all potential in-patient admissions; use of the incident reporting system to draw attention to lapses in protocol; investigation of all admissions that were not gate-kept, and the use of high status professionals, such as team leaders and consultant psychiatrists, to arbitrate in disputes.

The problem of delayed discharge was tackled in three sites by introducing a formal requirement for community teams to accept all CRHT clients referred to them within a set time period. However, community team leaders complained that this does not take account of resources within the receiving services, with the result that the problem may simply be shifted from one part of the system to another.

A bold attempt to address these problems was the decision on the part of one service (Site 8) to drop the gate-keeping requirement and allow direct access to HT to the Accident and the local hospital Emergency Liaison Team and to CMHTs. Initial fears of being swamped by inappropriate referrals had not materialized and the few clients judged not to have needed intensive HT had been quickly passed on to other services. These initiatives had released resources for HT and thereby increased the likelihood of meeting HT episode targets.

Discussion

Crisis Resolution and Home Treatment teams were conceived and introduced as extensions of the acute mental health service. The emphasis was on acute sector goals – reducing inpatient admissions and increasing patient through-put by reducing average length of stay. However, successful fulfillment of the CRHT role is not possible without close collaboration with community services, in particular CMHTs, and it is this dimension that seems to have been neglected in the original conception and operation of the CRHT function.

Shortage of in-patient beds increases the need for early discharge and pressure to reduce admissions, resulting in more clients in intensive HT, which in turn creates pressure for early discharge to CMHTs. As acute sector resources are squeezed, there is greater pressure on other services to take on more ill, more vulnerable and higher risk clients and, as these strains reverberate throughout the system, CMHTs may find themselves pressed to take on not only more clients but clients who pose higher risks and are more difficult to discharge back to primary care. For CRHTs, the balance between gate-keeping and HT can become difficult to sustain, with the former dominating to the detriment of the latter just when it is most needed.

Rather than being perceived primarily as gatekeepers to the acute service, protecting the scarce resource of hospital beds, it may be better to view the CRHT as an integral part of mental health service provision as a whole, as a resource for clients awaiting discharge or seeking to avoid hospital admission that is equally available to both acute and community services.

The evidence presented above suggests that co-operative relationships between CRHT and CMHT practitioners work best when: (i) senior CRHT members have experience of working in community as well as acute services and have regular contact with CMHT leaders; (ii) low staff turnover enables a level of trust to develop between the CRHT and acute and community teams and (iii) there is a degree of flexibility in working arrangements, for example CRHT provision of temporary weekend cover to vulnerable CMHT clients.

Previous research has focused on the boundary-spanning role (ability to work across group or organizational boundaries) of psychiatrists in the acute sector (Middleton et al., 2008). Our findings suggest that boundary-spanning is also important for CRHT workers in general, especially team leaders, and between the CRHT and community service.

Co-operation in the management of risk depends on trust between workers and between teams, and levels of trust seemed to be greatest where both workers and teams had a history of working together. This chimes with Middleton et al.'s (2008) finding that longer established or ''mature'' teams with a dedicated consultant psychiatrist were more effective gate-keepers than their counterparts. The CRHT ''needs time to 'bed in', which... means time for working relationships and expectations to evolve'' (Middleton et al., 2008, p. 379).

Our study suggests that staff retention may be an important factor in the development of inter-team and inter-professional trust. However, in the context of an aging mental health workforce and imminent loss of many experienced workers, the findings of a recent investigation (Huxley et al., 2011) that

significant numbers of community mental health workers report an intention to leave (especially within the more recently established specialist teams such as CRHTs) should be cause for concern. We were impressed by the strong service ethic and dedication of experienced staff working with some of the most difficult and vulnerable people in society, often in very challenging circumstances. This is a resource that should be managed with care.

Conclusion

To conclude, CRHTs are providing more than simply ''hospital in the community''. A better way of thinking about their role would be to see it as bridging the hospital-community interface, intervening at the sharp end of community care and facilitating early discharge by providing community-based rehabilitation. Our research suggests that the model is likely to be most effective when there is successful collaboration built on mutual trust between acute, CRHT and community services. In a climate of shrinking resources and the exit of experienced practitioners from the mental health workforce, this may be difficult to sustain as demand outstrips supply and each part of the service attempts to protect its resources, with service users the inevitable losers.

Limitations of the study

The study, as a whole, may not have done justice to what is a complex pattern of provision. Services were in the process of change, sometimes radical change and it is likely that all will be subject to further change, given current funding constraints and National Health Service reorganization. The findings presented represent common themes across sites, for which data saturation was achieved.

We were unable to explore the views of all stakeholders, in particular general practitioners and accident and emergency staff, both of whom are an important source of referrals to the CRHT service. No carers were interviewed and only three service users who may not have been representative and whose views have therefore been omitted from this analysis.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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